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ABSTRACT

The author considers group therapy as one of the most appropriate approaches to help psychotic patients, especially schizophrenics. He advocates the formation of four graded groups of patients based on the seriousness of their problems. The first is an intake group formed of newly admitted patients. Interaction in a group situation provides the psychiatrist a good opportunity to study the nature of the problems of each patient so as to place him in one of the other three groups. The second is a group for regressive patients, the most difficult cases with which to deal. The psychiatrist, with patience, understanding and support of a patient can gain his confidence and establish communication between the latter and the other members of the group, and then move him into the third group of less serious cases. With the latter group the emphasis is on correcting distorted perception and, through creating a healthy group atmosphere, initiate emotional and behavioral change. The fourth group is formed of predischarged patients who are allowed to join outpatients and family members. In this group, attempts are made to enhance self-esteem and recondition members to their immediate environments. (SE)

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SELECTIVE GROUP APPROACHES IN HOSPITAL SETTINGS

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While the title of this paper includes all nosological categories of psychosis, emphasis will be given to the schizophrenic patient. Different concepts about its genesis, the variety in its symptomatology and other factors such as cultural and environmental influences, all of these imponderabilities, have created difficulties in establishing reliable treatment criteria. It is no wonder then that a malady which is so complex in its cause and clinical manifestations leave the field open to controversy in approach and therapeutic speculation. However, it seems safe to state that according to our present day knowledge three main treatment strategies have lately been pursued, namely the chemo-biological, the psychological, and a combination of the two. The question whether individual or group therapy is a preferred treatment modality depends on orientation and the experience of the therapist. I regard group psychotherapy as treatment of choice.

The literature is replete with publications about group treatment of psychotics, which covers the whole gamut of approaches relating to composition, goals, techniques, and the types of groups. The diversity in treatment concepts is impressive and, as I mentioned, is un-

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doubtedly adjusted to the nature and complexity of psychotic illness.

I subscribe to the concept that schizophrenia is the end product of a pathological, selfperpetuating, evolutionary process, which is set in motion by a cause or combination of causes of genetic, constitutional, biochemical or environmental nature.

A recent study on psychotherapy of schizophrenia by Tucker and Maxmen has shown a definite ameliorative effect of psychoactive drugs, while psychotherapy has been 'negated as a viable therapeutic factor in the treatment of schizophrenia". While it has been admitted that this rather unfavorable verdict for psychotherapy may be the result of inadequate assessment procedure and unclarity of therapeutic intervention, it has reinforced doubts about psychotherapeutic effectiveness in schizophrenia.

Even if the above mentioned study evaluated only the individual treatment of schizophrenia, it has posed a challenge to group psychotherapy. Group treatment for the psychotic patient has so far been very much patterned along the lines of group therapy with neurotic patients. It is our contention that a model which would be aligned to the nature of psychotic illness could favorably influence therapeutic results. This paper deals with a program which emphasizes specifity in treatment approach.

One of the primary treatment considerations would be to provide opportunities for a correction in the patients' perception and experience in order to reduce the impact of the early psychic trauma and its sequential course of illness. In order to accomplish this, we would have to address our therapeutic efforts to the patients present state of emotional and functional capacities which means to adapt ourselves to the respective regressed level of his chronological age. This suggestion was originally advocated by Fromm-Reichmann and can easily be translated into the group situation. It would form the basis for a total group treatment program which would include a cluster of groups structured on a graded scale according to the degree of the members' pathology. Slavson suggested, already in 1961, a treatment device "of graded reality, i.e. an environment which is graded in complexity and demands as the patients' ego is strengthened and his inner resources increase". This sound principle has to my knowledge never been meaningfully applied and technically followed through. As mentioned, it would require the establishment of a number of groups which would be differentiated from each other by the patients' level of development. In spite of the autonomous function of each of these groups, they are part of a total treatment system which is based on a sequential scheme of ego develop-

ment. For example, in addition to the intake group there would be three groups in existence which would be attuned to the degree of the participants pathology, Group Level I representing the state of greatest regression. Such a graded structure would give the patients the opportunity to ascend to the next higher group level depending on the degree of his improvement.

On our ward unit at Bronx State Hospital, which is under the aegis of the Group Process Department, this cluster formation has been in operation for about six months. It consists of four groups, namely intake group and groups for regressed, chronic and predischarged patients. I will now address myself in detail to these groups. In describing them I have to ask for your indulgence to bear with me for repeating well known symptomatology and techniques which we experience in our daily group activities. However, it seems of greatest relevance that symptoms be seen in the context of each group, and that the techniques as well as the therapists' role be defined by the objective of each group. I regard as the main advantage of such a graded structure that it not only provides guidelines for selecting patients with similar needs and dynamics, but, and more importantly, it delineates goals, techniques and treatment procedure.

The intake group includes all new patients on the

ward, most of them acutely disturbed. The number of participants varies in size and depends on the rate of admissions. Since nearly all of these newcomers are under the influence of anti-psychotic drugs, it is a difficult function of the group leader to establish contact and gradually an empathetic relationship which makes the patient accessible to therapeutic intervention. Initial questions by the therapist, such as "What is the reason for your hospitalization?" may become the central theme of continued therapeutic focus since it sheds light on the patients vulnerability and all the repetitive signs of a pathology which has characterized his performance, attitude, and conduct in the past and which will manifest itself also on the hospital ward. In the group, which, in many ways, is a replica of real life, we can observe the specifity of setting, circumstance, and the nature of the interpersonal stimulus which elicits neurotic or psychotic motivation and reaction. Thus, the group process mirrors the patient's difficulties in his intrafamiliar and social interactions, and it is here that we can witness the whole qualitative range of his emotions, his utter helplessness as well as his unfulfilled needs.

Keen observation of all these phenomenological criteria enables the therapist to appraise the patients' psy-

chodynamics and ego resources which would then determine the selection for one of the following groups:

Group Level I: This group includes the regressed patient. With hardly any other type of psychosis is the therapists' function so difficult, demanding, time consuming, and often unrewarding as in the treatment of regressed psychotics. The patient finds himself in the straits between Scylla and Charybdis where the opposite choices of utter dependency and separation lurk dangerously over his head. To whichever side he gravitates he takes the risk of either surrendering to a victimizing parent-authority or finding himself on the lonely road of isolation.

Successful treatment of the severely regressed schizophrenic has been to the credit of those therapists, who possess specific personality characteristics. These personality traits seem to be: the faculty to tolerate and accept over extended periods of time, the failure or at best minimal success of their repeated therapeutic efforts; an insensitivity to the patients destructive behavior and at times uncontrollable rage, but a marked sensitivity to his ever-changing needs; and most of all a compassionate understanding of the patients' inner struggle and a motivating commitment to help. This combination of personality traits can not be accomplished by a successful

training analysis, but rather is the product of an inherent personality make-up. Hence not every therapist is qualified to treat this type of patient.

The very small group of not more than four members seems to be an ideal compromise setting for the regressed patient; it reduces the anxiety which he often experiences in individual treatment as well as in larger groups. The small group serves the therapeutic purpose of creating for him symbolically a small world which he never tested. By familiarizing himself with other participants with similar psychologic difficulties, he learns to correct his preconceived distorted perception of his environment. The interaction with other group members can become a meaningful experience from which he can learn and derive motivations for new interpersonal contacts.

Without minimizing the importance of group interaction, the main therapeutic consideration remains the therapist-patient relationship from which all members can benefit. The patients' emotional deprivation, his dependency wants and his weakened sense of identity can be alleviated by the therapist's warm, supportive, and communicative attitude. Attention should be paid to the patients' needs for oral gratification. This can be done literally by providing food, candies and so on, as well as symbolically by giving praise. Friendly facial gestures may often be

as meaningful as verbal recognition. The therapist's posture, the modulation and inflection of his voice are essential modes of communication which if properly used can have therapeutic effect. Tactile communication, such as touching, sitting next to the patient, holding his hands are at times desirable. It is always to be remembered that these patients' difficulties started on a preverbal level, that the process of good mothering includes tactile contact and affective and playful stimulation. Research conducted by Sobel about faulty care by schizophrenic mothers, or the well known "double bind phenomenon" by Bateson, underlines the importance of behavioral and non-verbal communication and its potentially detrimental effects on the child by generating confusion, distrust and doubt about the self and others. This kind of early perception of the environment may form the basis for psychopathology in varying degrees. At its severest, it will lead to an impasse in interhuman exchange and finally to alienation from the environment. To overcome the patients' protective distance seems to be the most formidable task for the therapist. It requires daily group sessions, which may even at times be reinforced by individual treatment, in order to strengthen the patients' interpersonal ties. The quality of the relationship which the patient is able to establish with the therapist is crucial and is the constant focus of our therapeutic considerations.

The patient will test, doubt, and challenge the therapist, but if he finally learns to trust him an important step is taken from which he can pass to the next group level.

Group Level II: In this group the therapeutic focus shifts from the individual and intrapsychic to extraversion and group concern. In the treatment of the regressed patient, we stressed the importance of the interpersonal and especially therapist-patient relationship as a prerequisite for behavioral change. The group utilizes the individual's emotional and functional potentials for making such changes. Only when the patient's ego is strengthened by integration of normal defense patterns is he ready to face confrontation and reality testing. To this end a group constellation is to be provided with opportunities for a wide variety of interactions. With the exception of the severely disturbed paranoid, any hospital patient can be admitted to this group which would be heterogeneous in sex, background, race and age. It would include people who clinically could be classified as psychotics, borderlines, and severe character disorders. These are patients with ego deficiencies, who under optimal conditions make marginal life adjustments, but break down under major stress. Their interpersonal relationships are colored by marked ambivalence and dissonant conduct; their daily tasks are carried out

in a perfunctory way. These individuals maintain a rigid protective system to stem the threatening onslaught of underlying anxieties. To enumerate the great variety of their defensive patterns would cover the whole field of psychopathology. However, I would like to point out a few inconspicuous behavior manifestations which easily escape our attention but have to be dealt with since they interfere with the patients daily functioning. I should like to quote a clinical illustration: A patient of mine, a successful, compulsively reliable person arrived late to her individual session. With visible tension she related her concern about her unusual lateness, which she ascribed to her time consuming pondering in a busy subway station missing trains because she was undecided which train to take to my office. To my question why she did not ask anyone for information, she replied that this would create too much anxiety and embarrassment and would be an admission of defeat. She added that all her life she had difficulty asking people for advice. Her history revealed that her critical mother expected of her, even at a relatively young age, to know, to give the right answers, and function logically. This patient represents the large group of pseudo-mature individuals who have been either emotionally deprived or overprotected and sent out into the world with good mental potentials, and whose pathology has never interfered with their cap-

acity for sound reasoning. However, they never learned the "hows" of simple functioning in the minor details of every day living. They feel strange with their environment and awkward in their social interactions. There are others who display quite a different picture. These are people who are socially skilled and function adequately and appropriately in their human contacts and tasks, but their performance is devoid of feelings and hence their actions become meaningless gestures.

To attain our treatment goal, a group atmosphere would have to be created which would lend itself to the tasks of emotional and behavioral change. Relearning would have to take place by very active intervention of the therapist. Inappropriate behavior, whether verbal or nonverbal, would have to be intercepted and distorted perception would have to be clarified and corrected. It is a function of the group therapist to convey to the patients convincingly by demonstration that there are alternatives in experience and behavior which secure greater adaptive mobility even under stressful circumstances.

Group Level III: The trend in psychiatry which advocates avoidance of prolonged hospitalization emphasizes the necessity for a meaningful program for patients who are eligible for discharge. If we regard the purpose of short-term hospitalization with its limitations in time

and personnel as an emergency repair of an acute or reactivated psychic trauma then our goal cannot be rehabilitation but rather restitution to the optimal level of the patients prehospitalization state. Such considerations then determine our therapy for Group III which is composed of predischarged patients. This group is in principle closest to that of post hospitalized outpatient groups. By loosening the firm boundaries, which delineated the former groups, we create a two-way street between intra and extra-mural groups. This means that hospitalized patients could join outpatient groups and vice-versa, a composition which could be mutually beneficial for both groups. Adequate ego strength and stability are prerequisites for coping with the adversities of every day living. Difficulties and tension in interpersonal relationships in the group can be utilized by relating them to situations which occur outside the hospital. Widening the range and refining the qualities of the patients' adaptive skill enhances his self-esteem and heightens his confidences in his ability to master the demands placed upon him in the community or family. Occasional inclusion of family members into the group may be helpful to evaluate and if necessary recondition the patients' immediate environment as a preventive approach against unfavorable external influences. Different

kinds of group involvement, such as therapeutic community or staff-patient meetings, discussion and other activity groups have emphasized the therapeutic importance of the social system with its tension, conflict, and resolution. The patients' participation in such groups have paved the way for his social adjustment. After all, it is the group approach as a viable therapeutic modality which provides for the patient the social nexus which will help him to eliminate or at least to lower the barriers which have confined him to a state of sterile isolated existence.

Summary

This paper stresses the group treatment of psychotics, with special reference to the schizophrenic. Its causal fixation as well as the course of its development enables us to establish a graded structure of a number of interrelated groups which are differentiated from each other by autonomous principles. This group system simplifies criteria for composition, techniques, and the therapists role. Clinical material illustrates the different group phases.

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